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REVIEW OF ACTIVITIES OF THE UNITED NATIONS SYSTEM RELATING TO INDIGENOUS PEOPLES: AN INTERACTIVE DISCUSSION

Information received from the United Nations system

WORLD HEALTH ORGANIZATION (WHO) ACTIVITIES ON THE HEALTH OF INDIGENOUS AND TRIBAL PEOPLES

Introduction

1. In the context of the International Decade of the World's Indigenous Peoples, a number of resolutions have been adopted by the World Health Assembly requesting action throughout all levels of the organization. Key among these are resolution 51.24, adopted in 1998, which called on the WHO secretariat to report annually on progress on indigenous health initiatives; resolution WHA 53.10, adopted in May 2000, calling for the creation of both global and regional plans of action, based where feasible on the recommendations made by indigenous participants at the International Consultation on the Health of Indigenous Peoples held at WHO in November 1999; and the most recent, resolution WHA 54.16 of May 2001, requesting WHO to prepare an outline for a global strategy on indigenous health for consideration by the Assembly at the May 2002 session.

2. Work on indigenous and tribal peoples' (ITP) health should be seen in the context of two main themes which currently inform all WHO's work in line with international development goals. These are the themes of equity in health, and of poverty reduction. Together, these themes seek to assist member States in providing equitable health outcomes across all population groups, and provide the broad health and development framework in which issues of health and ethnicity are addressed.

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Indigenous health: a brief overview

3. Systematic and reliable information on the health and demographic status of indigenous and tribal peoples is scarce, and even in industrialized countries where considerable health research has taken place, a consistent national picture is often hard to obtain. Nevertheless, consistent patterns emerge. These show that indigenous and tribal peoples often have higher morbidity and mortality rates than other population groups, lower life expectancy, and higher infant and child mortality rates. Basic services (e.g. water, sanitation, energy, transport) tend to be less frequently available in areas where indigenous communities are highly concentrated, and environmental quality is often low. Chemical contamination threatens the safety and availability of traditional food sources, while major development projects often diminish habitats and natural resources.

4. Trends show that indigenous and tribal peoples in developing countries, particularly those in high or remote areas, are susceptible to malnutrition and diarrhoeal disease, as well as malaria and tuberculosis. Injuries and disabilities affect high proportions of indigenous and tribal peoples in both developed and developing countries, due in part to their heavy participation in informal migrant labour forces operating beyond the range of health and safety regulations. Disease patterns most often found in developing countries are also found among indigenous communities in industrialized countries. While infant mortality rates among indigenous peoples in some countries are dropping due to intensive efforts including vaccination campaigns, child mortality rates are in some cases increasing as the determinants of health remain largely unchanged.

5. The non-communicable and lifestyle diseases most commonly associated with indigenous peoples in developed countries (diabetes, mental health issues, substance use and violence-related injuries) occur mainly in a small number of countries - Australia, New Zealand, Canada, the United States of America, and Denmark (Greenland). The HIV/AIDS pandemic threatens health, social and economic security everywhere, particularly among the socially vulnerable. Insufficient access to culturally appropriate health services exacerbates the problems.

6. For health equity approaches to be successful, systematic health and demographic information on all marginalized and disadvantaged groups, including indigenous and tribal peoples, is needed. At the same time, the increasing calls of indigenous and tribal peoples to be centrally involved in decisions affecting their health have to be heeded.

Framework for a global strategy on indigenous health

7. In response to recent resolutions adopted by the World Health Assembly, the Department of Health and Development of WHO is coordinating the elaboration of an outline for a global strategy on indigenous health. Such a strategy will broadly identify common areas of relevance, but regions and countries themselves must be the major actors and key stakeholders in the development of plans of work relevant to national and local realities, and the needs and priorities of indigenous and tribal peoples in widely varying settings and contexts.

8. WHO's main role, in the light of its function as a normative and technical cooperation agency, will be to help generate evidence and locate existing best practices to assist member States wishing to become more involved in this area of work. A first draft of this outline will be discussed at the World Health Assembly in May 2002. At the time of writing, consensus on the contents of the document across all WHO Regions has still to be reached. Drawing on existing indications of priorities for indigenous and tribal peoples in the area of health, it will, however, include recommendations that work take place in the following broad areas:

Health and demographic data and information, to facilitate the acquisition and dissemination of systematic and accurate information on health trends and disparities between population groups;

Improving the capacity of health systems to respond to the health needs of the poor in general and marginalized populations in particular;

Identifying the determinants of health for marginalized populations, and integrating objectives in this respect into non-health sector policies and strategies;

Increasing access by indigenous and tribal peoples to information on disease prevention and health promotion (the health risks, conditions, and determinants to which their socio-economic status, lifestyles, livelihoods and habitats are likely to expose them);

The need for increased political commitment and enhanced national capacity to address these issues.

9. The World Health Assembly will review the draft outline in May 2002 and recommend further action. As with other major documents relating to indigenous and tribal issues, the process involved in finalizing a strategy acceptable to all stakeholders is likely to be complex and time-consuming.

Terminology

10. A wide variety of terminology is used across WHO's 6 Regions and 192 member States to address the question of health disparities between different population groups. A global strategy will need to take this variation into consideration, allowing terminology to remain as broad as possible. In each case, the member States concerned will need to identify the populations most vulnerable to health disparities, and the most appropriate umbrella under which they can be addressed. It is unlikely that one definition satisfying all Regions will be identified.

Past and present work carried out by WHO

11. Past and ongoing work of relevance to indigenous and tribal peoples' health includes the following:

(a) Establishment by the Pan American Health Organization in 1993 of the Indigenous Peoples' Health Initiative, as a contribution to the Decade. Work carried out under

its auspices concentrates on three main areas: strategic planning and alliances; intercultural frameworks and models of care; and information to detect and monitor inequalities. A series of documents and country profiles has been produced;[1]

(b) The work of the Traditional Medicine programme at WHO. This programme provides normative and country programme support to member States to help them develop their traditional medicine systems and integrate these into their national health care systems to ensure the appropriate, safe and effective use of traditional medicine.[2] It does not have a specific focus on indigenous peoples;

(c) Development of a framework for indigenous communities in managing substance abuse, piloted in Australia, New Zealand, Argentina, and Tonga (mid-1990s). Work resulting from this initiative is still ongoing in Argentina and New Zealand;

(d) Publication by the Mental Health Department of a document in the Nations for Mental Health series, entitled "The Mental Health of Indigenous Peoples: an international overview" (WHO/MNH/NAM/99.1);

(e) Preparation in 1997 of a document on the health of indigenous peoples by Dr. E.W. Alderete, University of Jujuy, Argentina, which has been widely used as a background document in many international conferences. WHO is currently investigating possibilities of making this an official WHO document;

(f) Holding of an International Consultation on Health of Indigenous Peoples at WHO headquarters in November 1999. A series of recommendations was made by the indigenous participants, and the indigenous caucus held parallel to the meeting drew up and adopted the Geneva Declaration on the Health and Survival of Indigenous Peoples (WHO/HSD/00.1);

(g) Contract to the Russian Association of Indigenous Peoples of the North (RAIPON) for preparation of a document on State policies relating to the health of indigenous peoples in Russia (2000);

(h) Preparation by PAHO in 2001 of a document on health and ethnicity in the context of the Americas (Spanish, Portuguese, English) (ISBN 92 75 07386 4);

(i) First version of a Global Compendium of Indigenous Health Research Institutions prepared (2001) (WHO/HDE/HID/01.2);

(j) Financial support to a United Nations Environment Programme/Arctic Council project on health and environment in the Russian Arctic region (2001);

(k) Preparation, in collaboration with an indigenous research centre in Canada, of a Participatory Research Management Guideline to assist the ethical conduct of health research involving indigenous and tribal peoples (work in progress);

(l) Elaboration by the African Regional Office of a framework to address indigenous, tribal and ethnic health issues (work in progress). Preparation of a case study on the health impacts of marginalization on pastoralist communities in Burkina Faso;

(m) Preparation by the Western Pacific Regional Office of case studies on the health status of ethnic populations in the Philippines, Malaysia and Viet Nam (work in progress).

Conclusion

12. The wide social, geographic, cultural and political diversity of WHO's Regions, and the differing approaches to health issues taken by member States within these Regions, make the establishment of common positions challenging. This challenge is made greater by the need to ensure that the policies, strategies and interventions adopted have the full endorsement of the intended beneficiaries. WHO looks forward to addressing and resolving many of these challenges in cooperation with the United Nations Permanent Forum on Indigenous Issues, and with partner organizations of the United Nations system.

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[1] For further information on the PAHO Initiative, please contact the officer in charge, Dr. Sandra Land (landsand@paho.org). Also, see the PAHO web site - http//:www.paho.org.

[2] For further information and documentation on the WHO Traditional Medicine programme, please contact Dr. X. Zhang, Acting Coordinator, TRM/HTP, at WHO headquarters, Geneva, Switzerland.